

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0039255</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Park Ridge Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>665 Busse Highway</u> <u>Park Ridge</u> <u>60068</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(847) 679-8219</u> Fax # <u>(847) 679-7377</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Lisa M. Hanlon, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
IDPA ID Number: <u>363920572001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>12/01/93</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>46</u>	Skilled (SNF)	<u>46</u>	<u>16,790</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>46</u>	TOTALS	<u>46</u>	<u>16,790</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF		<u>343</u>	<u>1,096</u>	<u>1,439</u>	8
9	SNF/PED					9
10	ICF	<u>7,721</u>	<u>3,941</u>	<u>458</u>	<u>12,120</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,721</u>	<u>4,284</u>	<u>1,554</u>	<u>13,559</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 80.76%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/01/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/01/93 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 46 and days of care provided 873Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Park Ridge Care Center

0039255

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	124,490	6,356		130,846		130,846		130,846		1
2	Food Purchase		70,882		70,882	(631)	70,251	(1,411)	68,840		2
3	Housekeeping	99,438	10,148		109,586		109,586		109,586		3
4	Laundry	22,224	5,807		28,031		28,031		28,031		4
5	Heat and Other Utilities			35,568	35,568		35,568	340	35,908		5
6	Maintenance	37,975	10,971	12,088	61,034		61,034	(265)	60,769		6
7	Other (specify):*										7
8	TOTAL General Services	284,127	104,164	47,656	435,947	(631)	435,316	(1,336)	433,980		8
	B. Health Care and Programs										
9	Medical Director			7,500	7,500		7,500		7,500		9
10	Nursing and Medical Records	635,355	34,819	17,540	687,714		687,714	(41)	687,673		10
10a	Therapy										10a
11	Activities		7,069	1,104	8,173		8,173		8,173		11
12	Social Services	2,246			2,246		2,246		2,246		12
13	Nurse Aide Training										13
14	Program Transportation			100	100		100		100		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	637,601	41,888	26,244	705,733		705,733	(41)	705,692		16
	C. General Administration										
17	Administrative	75,713			75,713		75,713	19,672	95,385		17
18	Directors Fees										18
19	Professional Services			38,567	38,567	4,935	43,502	(23,369)	20,133		19
20	Dues, Fees, Subscriptions & Promotions			11,485	11,485		11,485	(6,479)	5,006		20
21	Clerical & General Office Expenses	14,409	7,737	23,574	45,720		45,720	5,426	51,146		21
22	Employee Benefits & Payroll Taxes			144,412	144,412	631	145,043	(166)	144,877		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,425	1,425		1,425	187	1,612		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			43,535	43,535		43,535	1,019	44,554		26
27	Other (specify):*							3,808	3,808		27
28	TOTAL General Administration	90,122	7,737	262,998	360,857	5,566	366,423	98	366,521		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,011,850	153,789	336,898	1,502,537	4,935	1,507,472	(1,279)	1,506,193		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Park Ridge Care Center

#0039255

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			24,019	24,019		24,019	27,974	51,993			30
31	Amortization of Pre-Op. & Org.							623	623			31
32	Interest			4,053	4,053		4,053	72,424	76,477			32
33	Real Estate Taxes			88,694	88,694	(4,935)	83,759	824	84,583			33
34	Rent-Facility & Grounds			104,450	104,450		104,450	(104,450)				34
35	Rent-Equipment & Vehicles			4,589	4,589		4,589	2,269	6,858			35
36	Other (specify):*											36
37	TOTAL Ownership			225,805	225,805	(4,935)	220,870	(336)	220,534			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,273	35,341	59,614		59,614	(1,250)	58,364			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,185	25,185		25,185		25,185			42
43	Other (specify):*	9,113			9,113		9,113	(9,113)				43
44	TOTAL Special Cost Centers	9,113	24,273	60,526	93,912		93,912	(10,363)	83,549			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,020,963	178,062	623,229	1,822,254		1,822,254	(11,978)	1,810,276			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255Report Period Beginning: 01/01/03Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,098)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(197)	02		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(224)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,823)	21		18
19	Entertainment				19
20	Contributions	(150)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,000)	21		24
25	Fund Raising, Advertising and Promotional	(5,941)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(15,434)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,867)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	24,889		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 24,889		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (11,978)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS			Page 5A
Park Ridge Care Center			
ID# 0039255			
Report Period Beginning:	01/01/03		
Ending:	12/31/03		
NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	CLIC COPI	5	20
2	Bank Charges	(435)	21
3	Interest Income	(984)	32
4	Rent Apartment	(1,250)	34
5	Duplicate Legal Invoices	(253)	49
6	PPA Repairs & Maintenance	(536)	46
7	PPA Hospital Insurance	(166)	22
8	PPA Office Expense	(774)	21
9	PPA Food	(998)	82
10	Trust Fees - Building Company	(200)	31
11	Marketing Salaries	(9,113)	42
12			12
13			13
14			14
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96			96
97			97
98			98
99			99
100			100
101	Total	(15,434)	101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **Park Ridge Care Center**# **0039255**

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(1,411)											(1,411)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities				340								340	5
6	Maintenance	(536)			271								(265)	6
7	Other (specify):*													7
8	TOTAL General Services	(1,947)			611								(1,336)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(41)									(41)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs			(41)									(41)	16
	C. General Administration													
17	Administrative					19,672							19,672	17
18	Directors Fees													18
19	Professional Services	(293)			(23,076)								(23,369)	19
20	Fees, Subscriptions & Promotions	(6,787)			308								(6,479)	20
21	Clerical & General Office Expenses	(9,229)	200		12,419	2,036							5,426	21
22	Employee Benefits & Payroll Taxes	(166)											(166)	22
23	Inservice Training & Education													23
24	Travel and Seminar				187								187	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice				1,019								1,019	26
27	Other (specify):*				2,123		1,685						3,808	27
28	TOTAL General Administration	(16,475)	200		(7,020)	21,708	1,685						98	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(18,422)	200	(41)	(6,409)	21,708	1,685						(1,279)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **Park Ridge Care Center**# **0039255**

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(7,098)	33,923		1,149								27,974	30
31	Amortization of Pre-Op. & Org.		623										623	31
32	Interest	(984)	72,321		1,087								72,424	32
33	Real Estate Taxes				824								824	33
34	Rent-Facility & Grounds	(1,250)	(103,200)										(104,450)	34
35	Rent-Equipment & Vehicles				2,269								2,269	35
36	Other (specify):*													36
37	TOTAL Ownership	(9,332)	3,667		5,329								(336)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers			(1,250)									(1,250)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(9,113)											(9,113)	43
44	TOTAL Special Cost Centers	(9,113)		(1,250)									(10,363)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(36,867)	3,867	(1,291)	(1,080)	21,708	1,685						(11,978)	45

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental Income	\$ 103,200	665 Busse Highway Ltd. Partnership	100.00%	\$	\$ (103,200)	1
2	V	32 Interest Income	245	665 Busse Highway Ltd. Partnership	100.00%		(245)	2
3	V	31 Aortization		665 Busse Highway Ltd. Partnership	100.00%	623	623	3
4	V	30 Depreciation		665 Busse Highway Ltd. Partnership	100.00%	33,923	33,923	4
5	V	32 Interest - Harris Bank		665 Busse Highway Ltd. Partnership	100.00%	72,566	72,566	5
6	V	21 Trust Fees		665 Busse Highway Ltd. Partnership	100.00%	200	200	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 103,445			\$ 107,312	\$ * 3,867	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Park Ridge Care Center**# **0039255**Report Period Beginning: **01/01/03**Ending: **12/31/03****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	10 MEDICAL SUPPLIES	163	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	122	\$	(41) 15
16	V	39 ANCILLARY EXPENSE	4,949	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	3,699		(1,250) 16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 5,112			\$ 3,821	\$ *	(1,291) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Park Ridge Care Center**# **0039255**Report Period Beginning: **01/01/03**Ending: **12/31/03****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5 UTILITIES	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$ 340	\$ 340	15
16	V	6 REPAIRS & MAINT.		DYNAMIC HEALTH CARE CONS.		271	271	16
17	V	7 EMP.BEN. - GEN. SERVICES		DYNAMIC HEALTH CARE CONS.				17
18	V	19 PROFESSIONAL FEES		DYNAMIC HEALTH CARE CONS.		924	924	18
19	V	20 DUES AND SUBSCRIPTIONS		DYNAMIC HEALTH CARE CONS.		308	308	19
20	V	21 CLERICAL & GENERAL		DYNAMIC HEALTH CARE CONS.		12,419	12,419	20
21	V	24 SEMINARS AND TRAVEL		DYNAMIC HEALTH CARE CONS.		187	187	21
22	V	26 INSURANCE		DYNAMIC HEALTH CARE CONS.		1,019	1,019	22
23	V	27 EMP.BEN. - GEN. ADMIN.		DYNAMIC HEALTH CARE CONS.		2,123	2,123	23
24	V	30 DEPRECIATION		DYNAMIC HEALTH CARE CONS.		1,149	1,149	24
25	V	32 INTEREST		DYNAMIC HEALTH CARE CONS.		1,087	1,087	25
26	V	33 REAL ESTATE TAXES		DYNAMIC HEALTH CARE CONS.		824	824	26
27	V	35 EQUIPMENT RENTAL		DYNAMIC HEALTH CARE CONS.		2,269	2,269	27
28	V							28
29	V	19 Bookkeeping Fees	24,000	DYNAMIC HEALTHCARE CONS.			(24,000)	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 24,000			\$ 22,920	\$ * (1,080)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Park Ridge Care Center**# **0039255**Report Period Beginning: **01/01/03**Ending: **12/31/03****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 MAINT. CMP. - D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$	\$	15
16	V	17 ADMIN. CMP. - M. MAUER				12,143	12,143	16
17	V	17 ADMIN. CMP. - M. AARON						17
18	V	17 ADMIN. CMP. - F. AARON						18
19	V	17 ADMIN. CMP. - S. GOLDSTEIN						19
20	V	17 ADMIN. CMP. - S. KOPLIN						20
21	V	17 ADMIN. CMP. - D. MAGAFAS				3,354	3,354	21
22	V	17 ADMIN. CMP. - S. BOGEN						22
23	V	17 ADMIN. CMP. - S. LEVY				4,175	4,175	23
24	V	17 ADMIN. CMP. - HOWARD ALTER						24
25	V	17 ADMIN. CMP. - NON-OWNER						25
26	V	21 CLERICAL CMP. - S. AARON				2,036	2,036	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 21,708	\$ * 21,708	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Park Ridge Care Center**# **0039255**Report Period Beginning: **01/01/03**Ending: **12/31/03**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	7 EMP. BEN.- D. NEHMER	\$	DYNAMIC HEALTH CARE CONS.	100.00%	\$	\$	15
16	V	27 EMP. BEN.- M. MAUER				385	385	16
17	V	27 EMP. BEN.- M. AARON						17
18	V	27 EMP. BEN.- F. AARON						18
19	V	27 EMP. BEN.- S. GOLDSTEIN						19
20	V	27 EMP. BEN.- S. KOPLIN						20
21	V	27 EMP. BEN.- D. MAGAFAS				295	295	21
22	V	27 EMP. BEN.- S. BOGEN						22
23	V	27 EMP. BEN.- S. LEVY				604	604	23
24	V	27 EMP. BEN.- HOWARD ALTER						24
25	V	27 EMP. BEN.- NON-OWNER						25
26	V	27 EMP. BEN.- S. AARON				401	401	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 1,685	\$ * 1,685	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center # 0039255 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sherry Mauer	Owner	Administrative	25.00%	See Attached	3.33	9.00%		\$		1
2	Marshall Mauer	Relative	Administrative		See Attached	1.30	3.24%	Alloc Dynamic	12,143	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 12,143		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization LINCOLN MEDICAL SUPPLIES, INC.Street Address 3359 W. MAIN STREETCity / State / Zip Code SKOKIE, IL. 60076Phone Number (847) 679-8219Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>10</u>	<u>MEDICAL SUPPLIES</u>	<u>DIRECT ALLOCATION</u>					122	1
2	<u>39</u>	<u>ANCILLARY EXPENSE</u>	<u>DIRECT ALLOCATION</u>					3,699	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 3,821	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTH CARE CONS.Street Address 3359 W. MAIN STREETCity / State / Zip Code SKOKIE, IL. 60076Phone Number (847) 679-8219Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	423,801	12	\$ 10,611	\$	13,559	\$ 340	1
2	6 REPAIRS & MAINT.	PATIENT DAYS	423,801	12	8,462		13,559	271	2
3	7 EMP.BEN. - GEN. SERVICES	PATIENT DAYS	423,801	12			13,559		3
4	19 PROFESSIONAL FEES	PATIENT DAYS	423,801	12	28,879		13,559	924	4
5	20 DUES AND SUBSCRIPTIONS	PATIENT DAYS	423,801	12	9,628		13,559	308	5
6	21 CLERICAL & GENERAL	PATIENT DAYS	423,801	12	388,179	279,093	13,559	12,419	6
7	24 SEMINARS AND TRAVEL	PATIENT DAYS	423,801	12	5,844		13,559	187	7
8	26 INSURANCE	PATIENT DAYS	423,801	12	31,856		13,559	1,019	8
9	27 EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	423,801	12	66,362		13,559	2,123	9
10	30 DEPRECIATION	PATIENT DAYS	423,801	12	35,898		13,559	1,149	10
11	32 INTEREST	PATIENT DAYS	423,801	12	33,975		13,559	1,087	11
12	33 REAL ESTATE TAXES	PATIENT DAYS	423,801	12	25,761		13,559	824	12
13	35 EQUIPMENT RENTAL	PATIENT DAYS	423,801	12	70,935		13,559	2,269	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 716,390	\$ 279,093		\$ 22,920	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTH CARE CONS.Street Address 3359 W. MAIN STREETCity / State / Zip Code SKOKIE, IL. 60076Phone Number (847) 679-8219Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6 MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	9	59,901	59,901			1
2	17 ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	11	373,726	373,726	1	12,143	2
3	17 ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	40	9	490,141	490,141			3
4	17 ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	191,118	191,118			4
5	17 ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	40	3	49,500	49,500			5
6	17 ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	40	7	69,097	69,097			6
7	17 ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	9	77,417	77,417	2	3,354	7
8	17 ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	11	2	40,545	40,545			8
9	17 ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	45	11	128,818	128,818	1	4,175	9
10	17 ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	12,000	12,000			10
11	17 ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	11	153,735	153,735			11
12	21 CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	11	62,676	62,676	1	2,036	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,708,674	\$ 1,708,675		\$ 21,708	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization DYNAMIC HEALTH CARE CONS.Street Address 3359 W. MAIN STREETCity / State / Zip Code SKOKIE, IL. 60076Phone Number (847) 679-8219Fax Number (847) 679-7377

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40	9	5,106			1
2	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40	11	11,858	1	385	2
3	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	40	9	16,312			3
4	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45	6	32,071			4
5	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	40	3	26,160			5
6	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	40	7	26,142			6
7	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45	9	6,801	2	295	7
8	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	11	2	3,320			8
9	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	45	11	18,630	1	604	9
10	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40	1	4,292			10
11	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45	11	23,348			11
12	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40	11	12,346	1	401	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 186,386	\$		\$ 1,685	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Harris Bank & Trust		X	Mortgage			\$	1,189,564			\$	72,566	1
2	Lease Acceptance Corp.		X	Business Lease	\$395.00	05/25/02		21,434				403	2
3													3
4													4
5	See Supplemental Schedule											1,087	5
	Working Capital												
6	Harris Bank & Trust			Line Of Credit				45,000				2,545	6
7				Insurance								1,105	7
8	See Supplemental Schedule							6,093				(1,229)	8
9	TOTAL Facility Related				\$395.00		\$	21,434	\$	1,240,657			9
	B. Non-Facility Related*												
10													10
11													11
12													12
13	See Supplemental Schedule												13
14	TOTAL Non-Facility Related						\$		\$				14
15	TOTALS (line 9+line14)						\$	21,434	\$	1,240,657			15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # n/a

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Allocation From Dynamic		X				\$	\$			\$	1,087	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term											1,087	7
	Working Capital												
8	Interest Income						\$	\$			\$	(984)	8
9	Interest Income Bldg. Comp.											(245)	9
10	Security System							6,093					10
11													11
12													12
13													13
14	TOTAL Working Capital							6,093				(1,229)	14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Park Ridge Care Center**# **0039255** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2002 report.			\$ 89,165	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 88,683	2
3. Under or (over) accrual (line 2 minus line 1).			\$ (482)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 90,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$ (4,935)	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 84,583	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	75,966	8	
	1999	77,681	9	
	2000	78,932	10	
	2001	86,572	11	
	2002	87,859	12	
Accrual = 87,859 x 1.02% = 90,000 (Rounded) Allocated From Dynamic \$824.00				
Prior Period Legal Fee Of \$4,935 Was Reported On 12/31/02 Cost Report				
2002 Beginning Real Estate Accrual Adjusted By \$165 For Prior Year Assessment.				
				FOR OHF USE ONLY
				13 FROM R. E. TAX STATEMENT FOR 2002 \$ 13
				14 PLUS APPEAL COST FROM LINE 5 \$ 14
				15 LESS REFUND FROM LINE 6 \$ 15
				16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Ridge Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039255

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>09-27-213-053-000</u>	<u>Long Term Care Property</u>	\$ <u>87,858.80</u>	\$ <u>87,858.80</u>
2. <u>10-23-404-059-000</u>	<u>Allocated From Dynamic</u>	\$ <u>26,274.55</u>	\$ <u>840.62</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>114,133.35</u>	\$ <u>88,699.42</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Park Ridge Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039255

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet:

13,300

B. General Construction Type:

Exterior

Brick

Frame

Steel Stud

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:

3,441

2. Number of Years Over Which it is Being Amortized:

5 Years

3. Current Period Amortization:

623

4. Dates Incurred:

12/93

Nature of Costs:

Building Company Loan Costs

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 49,000	1
2					2
3	TOTALS			\$ 49,000	3

Facility Name & ID Number Park Ridge Care Center# 0039255

Report Period Beginning:

01/01/03

Ending:

12/31/03**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1994		8,310		20	416	416	3,043	9
10	Various		1995		33,691		20	1,685	1,685	11,436	10
11	Various		1997		21,547		20	1,077	1,077	6,218	11
12	Various		1998		18,893		20	946	(946)	4,950	12
13	Various		1999		7,527		20	378	378	1,683	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)			1,323,000	33,923		33,923		340,644	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)			14,192	364		405	41	4,190	68
69	Financial Statement Depreciation				16,132			(16,132)		69
70	TOTAL (lines 4 thru 69)			\$ 1,427,160	\$ 50,419		\$ 38,830	\$ (13,481)	\$ 372,164	70

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,427,160	\$ 50,419		\$ 38,830	\$ (11,589)	\$ 372,164	1
2	Condenser	2000	9,420		20	471	471	1,688	2
3	Air Conditioner	2000	757		20	38	38	136	3
4	Windows	2000	3,970		20	199	199	696	4
5	Windows	2000	9,433		20	472	472	1,690	5
6	Generator	2000	10,714		20	536	536	1,830	6
7	Generator Install	2000	7,942		20	397	397	1,356	7
8	Generator	2000	1,653		20	42	42	143	8
9	Portable Generator	2000	2,625		20	131	131	449	9
10	Rear Entrance Ramp	2000	2,350		20	118	118	392	10
11	Ramp Railings	2000	650		20	33	33	106	11
12	Security System	2000	21,434		20	1,072	1,072	3,840	12
13	Compressor	2001	1,100		20	110	110	312	13
14	Fence	2001	1,900		20	190	190	412	14
15	Boiler Repair	2001	625		20	31	31	89	15
16	Plumbin	2001	1,625		20	81	81	183	16
17	Fire Dampers	2002	2,500		20	125	125	198	17
18	Carpeting	2002	950		20	136	136	181	18
19	Blinds	2002	988		20	99	99	107	19
20	Circuit Board	2002	964		20	48	48	96	20
21	Duct Work	2002	1,200		20	60	60	80	21
22	Blinds	2003	4,400		20	440	440	440	22
23	Fire Alarm Equipment	2003	3,602		20	300	300	300	23
24	Masonry And Tuckpointing	2003	1,500		20	38	38	38	24
25	Wallcovering	2003	2,310		20	1,155	1,155	1,155	25
26	Curtains For Residents Rooms	2003	5,440		20	363	363	363	26
27	Tuckpointing	2003	1,500		20	31	31	31	27
28	Tuckpointing	2003	1,500		20	25	25	25	28
29	2 Cooling Units	2003	1,378		20	29	29	29	29
30	Tuckpointing	2003	1,500		20	19	19	19	30
31	Tuckpointing	2003	1,000		20	8	8	8	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **Park Ridge Care Center**

STATE OF ILLINOIS

0039255

Report Period Beginning:

01/01/03

Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **Park Ridge Care Center**

STATE OF ILLINOIS

0039255

Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12G, Carried Forward		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	34

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,534,090	\$ 50,419		\$ 45,627	\$ (4,792)	\$ 388,556	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	46		1993		\$ 1,323,000	\$ 33,923		\$ 33,923	\$	\$ 340,644	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37				\$	\$		\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)			\$ 1,323,000	\$ 33,923		\$ 33,923	\$	\$ 340,644	70

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Park Ridge Care Center

STATE OF ILLINOIS

0039255

Report Period Beginning:

01/01/03

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated From Dynamic Healthcare Consit.		1993	1993	\$ 14,192	\$ 364	35	\$ 405	\$ 41	\$ 4,190	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 14,192	\$ 364		\$ 405	\$ 41	\$ 4,190	70

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 56,537	\$ 7,970	\$ 5,592	\$ (2,378)	10	\$ 33,693	71
72	Current Year Purchases	2,814	397	258	(139)	10	258	72
73	Fully Depreciated Assets	117,728				10	117,728	73
74								74
75	TOTALS	\$ 177,079	\$ 8,367	\$ 5,850	\$ (2,517)		\$ 151,679	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated From Dynamic		\$ 1,801	\$ 305	\$ 516	\$ 211	5	\$ 1,765	76
77										77
78										78
79										79
80	TOTALS			\$ 1,801	\$ 305	\$ 516	\$ 211		\$ 1,765	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,761,970	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 59,091	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,993	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,098)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 542,000	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$		86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 6,858

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 16,658	\$		\$ 16,658	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			297			297	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			17,293			17,293	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				18,806		18,806	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					1,093	5,467		6,560	13
14	TOTAL			\$		\$ 35,341	\$ 24,273		\$ 59,614	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 78,972	\$ 112,825	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	362,627	362,627	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,453	11,453	6
7	Other Prepaid Expenses	1,971	1,971	7
8	Accounts Receivable (owners or related parties)	3,240	323,387	8
9	Other(specify): See Attached Schedule	82,361	83,389	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 540,624	\$ 895,652	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		49,000	13
14	Buildings, at Historical Cost		1,323,000	14
15	Leasehold Improvements, at Historical Cost	183,856	183,856	15
16	Equipment, at Historical Cost	78,245	78,245	16
17	Accumulated Depreciation (book methods)	(137,835)	(576,481)	17
18	Deferred Charges		98,000	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	1,367	1,367	22
23	Other(specify): See Attached Schedule		3,441	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 125,633	\$ 1,160,428	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 666,257	\$ 2,056,080	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 50,810	\$ 133,451	26
27	Officer's Accounts Payable	48,094	48,094	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	51,093	51,093	29
30	Accrued Salaries Payable	87,905	87,905	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,508	3,508	31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,000	90,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	64,400	67,841	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 395,810	\$ 481,892	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,189,564	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,189,564	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 395,810	\$ 1,671,456	46
47	TOTAL EQUITY (page 18, line 24)	\$ 270,447	\$ 384,624	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 666,257	\$ 2,056,080	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 331,877	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 331,877	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(61,430)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (61,430)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 270,447	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,731,939	1
2	Discounts and Allowances for all Levels	(106,989)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,624,950	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	94,270	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 94,270	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	25,836	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,731	19
20	Radiology and X-Ray		20
21	Other Medical Services	10,856	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 40,423	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	984	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 984	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	197	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 197	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,760,824	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	435,947	31
32	Health Care	705,733	32
33	General Administration	360,857	33
	B. Capital Expense		
34	Ownership	225,805	34
	C. Ancillary Expense		
35	Special Cost Centers	68,727	35
36	Provider Participation Fee	25,185	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,822,254	40
41	Income before Income Taxes (line 30 minus line 40)**	(61,430)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (61,430)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Park Ridge Care Center# 0039255Report Period Beginning: 01/01/03Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,946	2,113	\$ 61,397	\$ 29.06	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,511	6,866	186,044	27.10	3
4	Licensed Practical Nurses	513	516	10,556	20.46	4
5	Nurse Aides & Orderlies	27,343	29,799	361,748	12.14	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	150	150	2,246	14.97	11
12	Dietician					12
13	Food Service Supervisor	2,403	2,566	39,024	15.21	13
14	Head Cook	2,865	3,005	41,274	13.74	14
15	Cook Helpers/Assistants	4,343	4,667	44,192	9.47	15
16	Dishwashers					16
17	Maintenance Workers	1,957	2,094	37,975	18.14	17
18	Housekeepers	9,174	9,784	99,438	10.16	18
19	Laundry	2,004	2,178	22,224	10.20	19
20	Administrator	2,040	2,175	75,713	34.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,094	1,162	14,409	12.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,152	1,220	15,610	12.80	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	632	632	9,113	14.42	33
34	TOTAL (lines 1 - 33)	64,127	68,927	\$ 1,020,963 *	\$ 14.81	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	7,500	09-03	36
37	Medical Records Consultant	87	3,039	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	900	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,104	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	111	\$ 12,543		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	541	\$ 13,601	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	541	\$ 13,601		53

SEE ACCOUNTANTS' COMPILATION REPORT

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
Rob Weisz	Administrator	0%	\$ 75,713	Workers' Compensation Insurance	\$	31,356	IDPH License Fee	\$
				Unemployment Compensation Insurance		7,095	Advertising: Employee Recruitment	1,194
				FICA Taxes		77,742	Health Care Worker Background Check (Indicate # of checks performed)	
				Employee Health Insurance		28,052	ICLTC Dues	2,622
				Employee Meals		631	ICLTC COPE	(696)
				Illinois Municipal Retirement Fund (IMRF)*			Dues And Subscriptions	986
							Licenses And Permits	592
							Allocated From Dynamic	308
							Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)							TOTAL (agree to Sch. V, line 20, col. 8)	\$ 5,006
(List each licensed administrator separately.)			\$ 75,713					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	1,425
							Allocated From Dynamic	187
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 1,612
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Dynamic Healthcare Conslt.	Bookkeeping		\$ 24,000					
HDSI	Data Processing		3,182					
Sidney R. Berger	Legal		1,170					
Elliott & Associates	Legal		215					
Sachnoff & weaver, Ltd	Legal		110					
Frost, Ruttenberg & Rothblatt	Accounting		13,650					
Econocare	Purchasing Consultant		500					
Personnel Planners	Unemployenet Conslt.		675					
Elliott & Associates	PPA Real Estate Protest							
	Fee		(4,935)					
TOTAL (agree to Schedule V, line 19, column 3)								
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 38,567					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting & Decorating	1997	\$ 7,147	3	\$ 1,191	\$	\$	\$	\$	\$	\$	\$	\$
2	Painting & Decorating	1998	1,940	3	647	323							
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 9,087		\$ 1,838	\$ 323	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Park Ridge Care Center**

STATE OF ILLINOIS

0039255

Report Period Beginning:

01/01/03

Ending:

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12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$2,622
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,452 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 25,185
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 631 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Of Line 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.